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titioners and patients do not know the difference and buy the cheapest.[1]

These probably are among the chief reasons why 'the systems of oriental medicine have fallen into decay'. The task of improving the standard of health in the tropics is aggravated by the fact that western medical science usually reaches the people as one aspect of economic penetration, and must first be applied towards repairing and preventing the mischief naturally consequent on the process of development. A solution of the problem has been attempted along two lines: the provision of medical assistance; and the introduction of modern hygiene. It is important to notice the essential difference between these alternatives. Medical assistance aims to promote *individual* welfare, and ordinarily requires the voluntary co-operation of the patient; hygiene aims to promote *social* welfare, and necessarily involves a certain measure of compulsion.

2. MEDICINE

Ordinarily the introduction of western medicine in the tropics originates in the needs of Europeans. From very early days the East India Company arranged with the Apothecaries Company for the supply of barber-surgeons to their ships and settlements. In Africa likewise the various administrations at first confined the provision of medical services to the needs of their own establishments. But administrative establishments are partly native, and non-officials in commerce and industry require medical attention. In Burma the earliest members of the general public to receive the benefits of western medical skill were the convicts in jail, and the expansion of medical services in the interior has been closely bound up with the growth of crime. It is only natural that generally throughout the tropics the provision of medical assistance has developed with the economic demand for doctors, and has been organized so as to cost no more than necessary.

But the spread of western medicine in the tropics has not been due solely to the growing demand for doctors; it has been due in part to the demand for patients. Medical missionaries look for patients. It is true that missionary organizations need doctors to preserve the lives of missionaries. But they have also recognized in western medicine an instrument for extending their influence among the people. To deliver their message they must find some method of

[1] *RPI* (India), 1897–1902, p. 245; *CISM*, pp. 13, 15, 23.

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attracting listeners. Where, as under direct rule, the people want education in order to get jobs, missionaries have provided schools. Where, as under indirect rule, education has had less market value, they have provided hospitals. Missionaries have sought patients in the cause of welfare, hoping that by saving life they might rescue souls. Moreover the demand for patients has not been wholly altruistic. On western enterprise employers have come to recognize the economic value of providing medical attention for their labourers, in the hope that by improving health they might save labour. In Java under the Culture system the Government produce depended on the well-being of the plantation coolies and, in the forties, when the pressure on the labour supply led to famine and depopulation, it could no longer be disregarded. Thus, so early as 1851, a start was made in the training of natives in western medicine. In the same year Protestant missionaries were admitted. In Burma, developed by native enterprise under direct rule, missionaries have specialized in education, but in Java, developed by western enterprise under indirect rule, medical work presented a more favourable opening.

It is true, of course, that medical missions have looked on the provision of medical care as a good thing in itself, apart from ulterior motives, and that administrations and employers have been actuated by human sentiment in providing and extending medical facilities. Ordinarily the chief factor in stimulating humanitarian impulse has been the shock occasioned by a sensational outbreak of disease. In Siam the modern medical service dates from an epidemic of cholera in the early eighties; the ravages of sleeping sickness in 1901–2 focussed British attention on Uganda; shortly afterwards the outbreak of plague advertized the need for medical care in India and the Tropical Far East. But humanitarian considerations have been reinforced by the practical requirements of western enterprise, and it is in regions developed by western enterprise that medical work has made most progress. Of the hospitals in Java, other than dispensaries, about two-thirds are private institutions, and in the Outer Provinces nine-tenths.[1] In Malaya, before the late war, the tin and rubber companies were maintaining 232 hospitals. In Ceylon about three times as many were provided by companies managing estates, and there were about an equal number of Government dispensaries together with 93 State hospitals.[2] But Asiatic owners and

[1] *Netherlands India*, p. 380.
[2] *Britain and Her Dependencies*, pp. 29, 30.